Overview of the KDPCP and Diabetes in Kentucky

Kentucky Diabetes Prevention and Control Program (KDPCP)

Outline

- Welcome/Introduction
- Overview of the KY Diabetes Prevention and Control Program (KDPCP)
- Snapshot of Diabetes in KY

Kentucky Diabetes Prevention and Control Program (KDPCP)

KDPCP

- **Mission:** reduce new cases of diabetes as well as the sickness, disability and death associated with diabetes and its complications
- Almost 30 years old!
- Funded with state and federal funds
- The program works through a myriad of public and private partners (LHD, coalitions)
- All local health departments are included

KDPCP

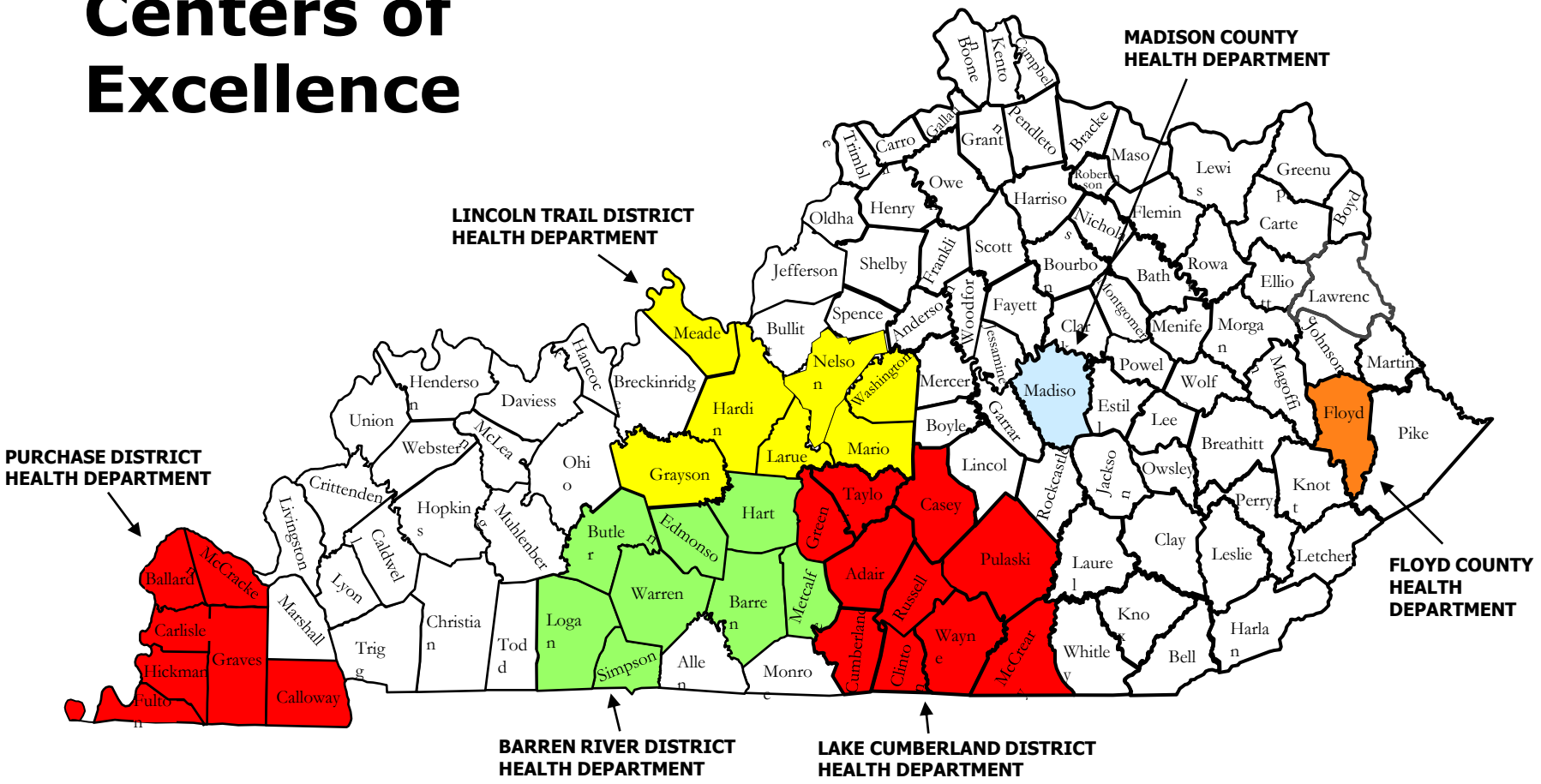
- KDPCP is involved in many activities (primarily population-based)
  - Community Mobilization
  - Public Awareness
  - Patient Self-Management Education
  - Professional Education/Quality Improvement
  - Surveillance/Evaluation
  - Disease Management/Diabetes Centers of Excellence (DCOE)
- Since the DCOE is relatively new, a few words about that

Diabetes Centers of Excellence

DCOE Background

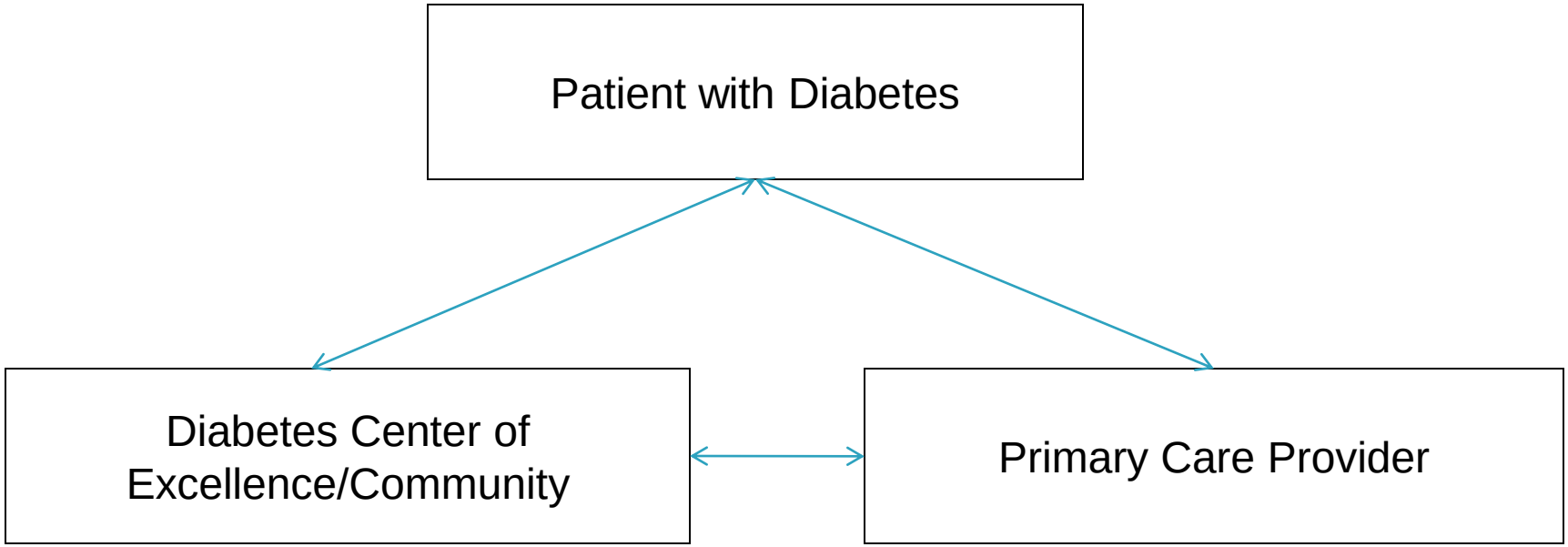
- Funded by the Legislature in 2007-08
- Goal: to improve outcomes and decrease costs among adult Medicaid recipients with diabetes
- Sites were fully operational in Spring of 2007
  - Barren River District
  - Floyd County
  - Lake Cumberland District
  - Lincoln Trail District
  - Madison County
  - Purchase District

Kentucky Diabetes Centers of Excellence



What is a DCOE?

Partnership between the patient, the PCP, and the LHD



DCOE Components

- Outreach
- Care Coordination and Tracking
- Patient Self-Management Education/Behavior Change Support
- Communication with the Primary Care Provider
- Documentation and Data Collection
- Health Systems Change

Outcomes/Success

Improvements In Meeting Standards of Care (2009)		
	% before	% after
Foot Exams	24%	53%
Eye Exams	22%	47%
Flu	28%	56%
Pneumonia	25%	39%
A1C (3 month average blood sugar)	% before	% after
> 9 (Very Out of Control)	22%	12%
< 7 (In Control)	45%	50%

Additional Disease Management Work

- In January, 2009, we assumed responsibility for 450 patients from a previous Medicaid disease management contractor
- These patients are located within a 10 county area – only 3 of which correspond to DCOE sites (Utilizing DOCE sites to cover this – with the addition of Fayette and Pike)
- Diabetes disease management services for a much larger group of Medicaid recipients may be a future opportunity??

Back to KDPCP

KDPCP

- All local health departments receive funding (cost center 809) to participate in the program – but at different levels of activity/funding:
  - Level 1
  - Level 2
  - Level 2.5
  - Level 3

So How Do I Know What Activities I am Responsible For?

- First – know your level designation
- Second - each year DPH and the LHDs participate in a plan and budget process
  - DPH sends a Guidance Document detailing program requirements for each program area/cost center and budget info.
  - LHD in turn submit a plan and budget to DPH for approval
- Diabetes plans are done in a system called CATALYST (this system is also used for reporting)
- Find a copy of your plan!

Level 1 Requirements

- **Requirement** - public awareness activities, aimed at the general public and those with or at risk for diabetes to raise awareness about all aspects of diabetes.
  - Examples: media activities, health fairs, presentations to civic or other community groups, and distribution of educational messages/materials being promoted by the state diabetes program.

Level 2 Requirements

- **Requirement** – all of the above plus
  - group educational programs in local communities that target behavior change in persons with or at risk for diabetes and their families – specifically, Comprehensive Diabetes Self-Management Education/Training (DSME/T)
    - Examples: DSME/T, cooking classes, weight loss classes, support groups

Level 2.5 Requirements

- **Requirements**: all of the above plus:
  - a variety of community mobilization/community change activities.
  - activities targeting local health professionals to improve the prevention and control of diabetes and the quality of diabetes care
  - Establishing/maintaining ongoing relationships with a variety of community partners in order to increase communication, coordination, collaboration, surveillance and advocacy concerning diabetes-related issues, as well as to facilitate identification of needs and the development of resources for the prevention, early detection, self-management, and appropriate care of people with diabetes.

Level 2.5 Requirements
(continued)

- Examples: professional education programs, partnership building with professional groups, the dissemination of standards of care and tools, the use of various quality improvement programs, participation in state-level coalitions, establishment of/participation in local coalitions, efforts to improve policies within schools, work sites, health systems, etc.,

Level 3 Requirements

- **Requirements:** all of the above plus projects of state-level significance as defined by KDPCP strategic plan
  - Examples: assessment and planning activities, curricula/materials development, training and mentoring of other LHD staff, leadership for state, and local coalitions, facilitation of professional diabetes networks that support diabetes education and educators

Diabetes In Kentucky

Diabetes In Kentucky

- Diabetes is:
  - Common
  - Serious
  - Costly
  - Controllable
  - Preventable

Diabetes is Common

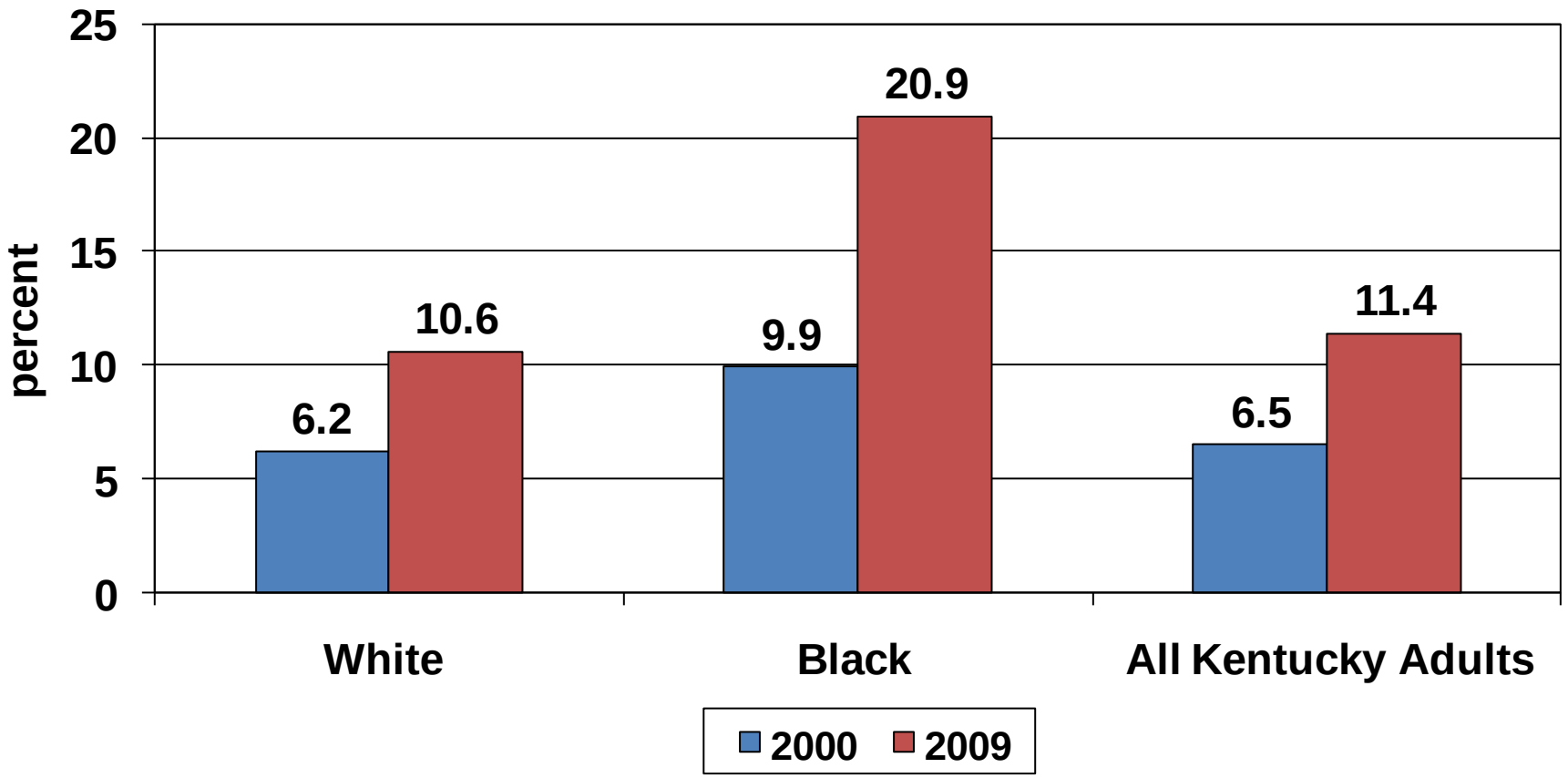
Diabetes in Kentucky

- An estimated 11.4% of the adult population (366,000) has been diagnosed with diabetes (2009)
- Kentucky ranks 4th in the nation for the highest prevalence of adults diagnosed with diabetes (2009)
- In 2000, fewer than 2% of Kentuckians aged 35-44 had been diagnosed with diabetes. By 2009, the rate for this age group was 8%

Populations At Risk

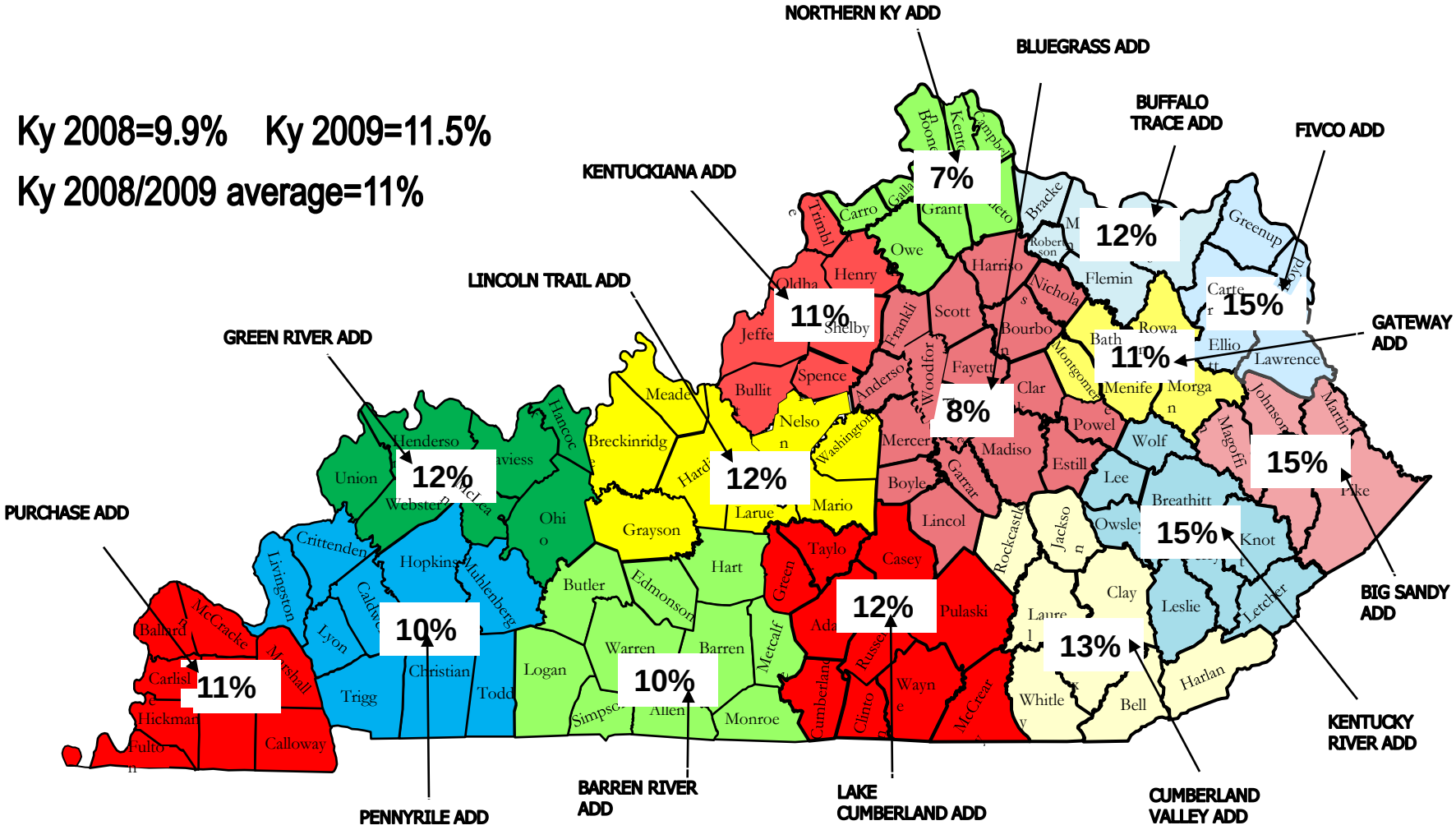
- In 2000, 14% of those > 65 had diabetes compared to 22% in 2009
- 20.9% of African Americans in Kentucky have diagnosed diabetes compared to 10.6% of whites (2009)
- Eastern/Southeastern Kentucky tend to have the highest prevalence rates of diabetes – but high rates are also seen in sections of Western Kentucky

Kentucky Adult Diabetes Prevalence by Race



Data Source: KY BRFSS

Geographic Distribution of Diabetes Prevalence Rates Among Kentucky Adults (2008/2009)



Data Source: 2009/2009 KY BRFSS Data

Adults At Risk for Diabetes

- In 2009, 32% of Kentucky adults (almost than 1 in 3) were obese (self reported)
- 64% of Kentucky adults have been told they have high blood pressure (2009)
- About 57% of adults report being tested for diabetes in the past 3 yrs. Of those, 8% (235,000) have been diagnosed as having **Pre-diabetes** and are at very high risk for developing diabetes

Diabetes is Serious

Diabetes Is Serious

- The 5th leading cause of death by disease
- The leading cause of:
  - Adult blindness
  - Kidney failure
  - Non-traumatic lower extremity amputation
- There were 199,207 diabetes-related hospitalizations in KY in 2007 (17.9% of all hospitalizations)

Diabetes is Costly

Diabetes Costs – Staggering!

- The U.S. spends $174 billion annually on diabetes and its complications (2007)
  - Medical expenses for those with diabetes are 2.3 times higher than for those without diabetes
  - Undiagnosed diabetes is estimated to cost an additional $18 billion annually
  - Pre-diabetes is estimated to cost an additional $25 billion annually
- KY spends $2 billion annually on diabetes and its complications (2007)
- KY's Medicaid program spent more than $670 million to pay for services for with diabetes (2004)

Diabetes is Controllable and Preventable

The Good News!

Prevention of Diabetes

- The Diabetes Prevention Program (DPP) showed that moderate diet and exercise, resulting in a 5-7% weight loss, can delay and possibly prevent Type 2 diabetes.
- Study participants were overweight and had higher than normal levels of blood glucose (pre-diabetes)
- Lifestyle changes reduced the risk of developing diabetes by 58% over a 3 year period
- Lifestyle changes were effective for all ages, and ethnic groups

The Jury is in – Control Matters!

- Research tells us that diabetes control reduces complications in persons with both type 1 and type 2 diabetes.
- We now have more tools and therapies to help us achieve it than ever before.

Preventive Care Practices www.diabetes.org

- Self-management education/training
- Routine health care visits (every 3-6 months)
- Taking diabetes-related medications as prescribed
- Healthy meals
- Exercise (daily)
- A1C testing (2-4 times per year)
- Blood pressure checks (at each physician visit)
- Cholesterol checks (at least annually)
- Foot inspections (daily)
- Dilated eye exams (annually)
- Flu vaccination (annually)
- Pneumonia vaccination (once or twice in lifetime)
- Smoking cessation
- Dental exams (every six months)

Reported Preventive Care Practices among Adults with DM KY 2009 and US 2008

Preventive Care Practice	KY 2009	US 2008
Saw a health professional for diabetes ≥ 1 time in the past year	91%	87%
Ever taken a course or class in how to manage diabetes	**50%**	**56%**
Checked blood glucose ≥ 1 time per day	69%	64%
Received a dilated eye exam in the past year	60%	62%
Received a foot exam ≥ 1 time in the past year	67%	87%
Daily self-exam of feet	70%	64%
Received a flu vaccination in last year	53%	50%
Ever received a pneumonia vaccine	51%	40%
Had A1C checked ≥ 2 times in the past year	72%	68%

Source: BRFSS

So Data Shows…

- Diabetes is a serious, common, costly, but controllable and preventable disease in Kentucky
- We have good science that tells us how to control diabetes and prevent or delay much of the complications, cost, etc.
- We have good science that tells us we can prevent/delay diabetes itself
- There is a significant gap between desired outcomes and what is actually happening

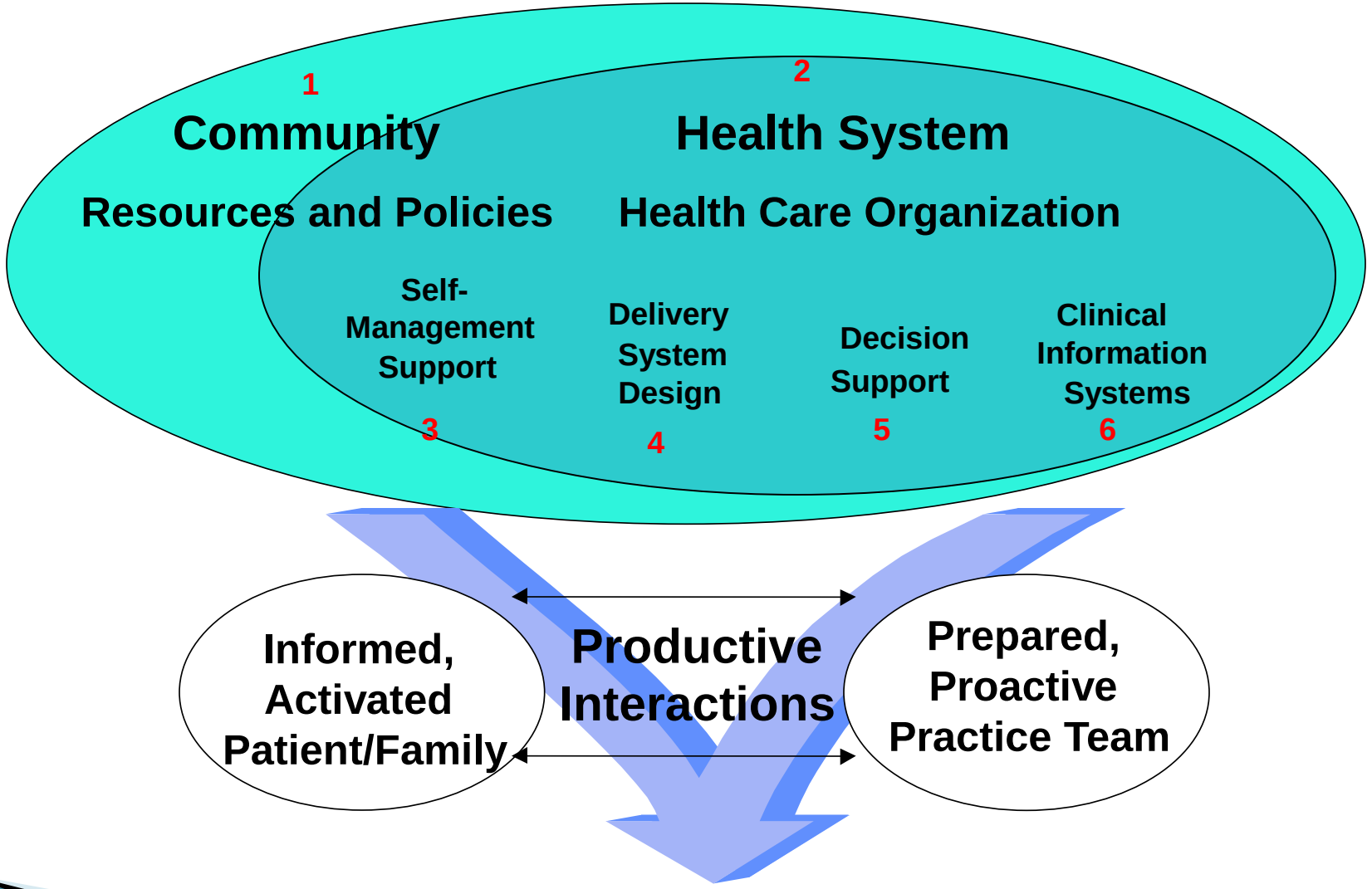
SO . . . . .

- We have come to realize that winning the war against diabetes will take much more than a doctor and a patient coming together in a one on one visit
- Our health care system is designed to treat acute episodic illness much more so than chronic disease
- So what works??

What Works?

- Informed, activated patient
  - Diabetes Self-Management Education
  - Services that support behavior change in the community
- Prepared, proactive health care team
  - Disease registries
  - Reminder systems/tools
- Chronic Care Model illustrates what works

Chronic Care Model



Adapted from: Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation
www.improvingchroniccare.org

Sound Familiar?

- Public Awareness/Education
- Patient Education/Self-Management Educ.
- Professional Education/QI
- Community Mobilization
- Disease management/DCOE

Summary

- Diabetes is a common, serious, costly but controllable/preventable disease in KY
- The KDPCP is a busy program with a myriad of activities and many local and state partners
- Welcome to KDPCP!